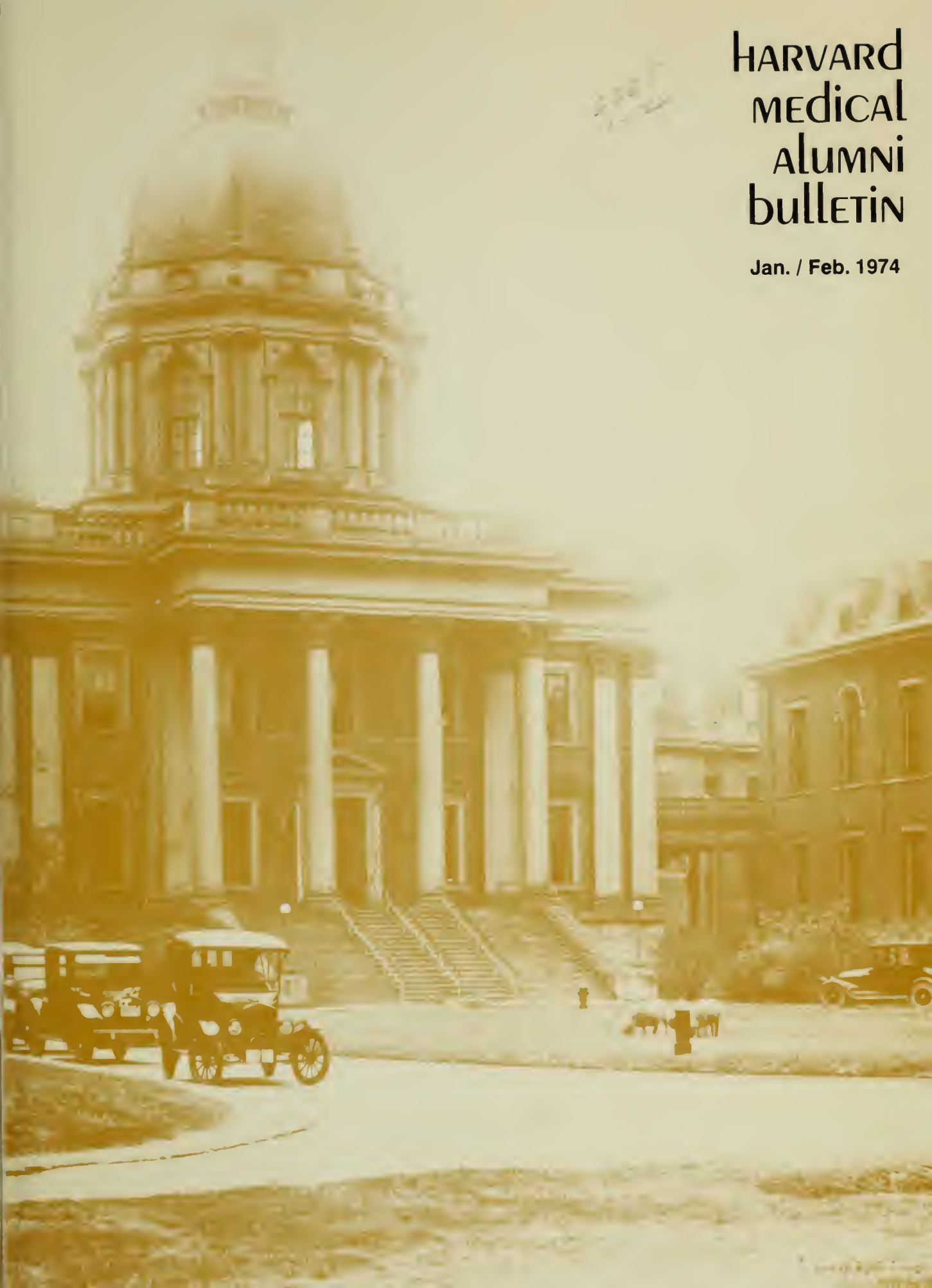
HARVARD MEDICAL ALUMNI BULLETIN

Jan. / Feb. 1974



When cardiac complaints occur in the absence of organic findings, underlying anxiety may be one factor

The influence of anxiety on heart function

Excessive anxiety is one of a combination of factors that may trigger a series of maladaptive functional reactions which can generate further anxiety. Often involved in this vicious circle are some cardiac arrhythmias, paroxysmal supraventricular tachycardia and premature systoles. When these symptoms resemble those associated with actual organic disease, the overanxious patient needs reassurance that they have no

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions

organic basis and that reduction of excessive anxiety and emotional overreaction would be medically beneficial.

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in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Harvard Medical Alumni Bulletin

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Cover: In the interest of economy and ecology, readers should take note of the type of lawn mower used in the early days of the Boston City Hospital. Perhaps we could resurrect this quaint idea on the Quadrangle during this energy saving era. For stories on Boston City Hospital, see page 6.

Credits: Courtesy of William V. McDermott, Jr., cover, p. 8, 13; courtesy of The Bostonian Society, Old State House, p. 6; Bradford Herzog, p. 9; courtesy of Countway Library Archives, p. 11, 12; Fabian Bachrach, p. 26.

Overview

HMS Alumni Invited to Harvard Comes to Florida

HMS alumni will find particular interest in Harvard University's visit to Miami on Saturday, 2 March 1974. A day of panel discussions of University issues and current economic problems will be climaxed by a dinner with President Derek C. Bok. Co-sponsoring the event are the Harvard Clubs of Miami and Broward County. The HMS Committee of the Harvard Club of Miami, led by John H. Talbott '28 and Rufus K. Broadaway '50, are involved in the planning, and encourages all HMS alumni to attend.

The program will begin with a panel entitled, "The Liberal Arts Undergraduate at Harvard and Radcliffe." Three of the University's top spokesmen will discuss challenging issues related to undergraduate education, such as the admissions' process, women's educational needs and realities, and creating the future of Harvard education.

The featured panel on economics, "The Economy in Trouble: Agriculture, Energy, and other Horrors," will present three of Harvard's leading economists. Ray A. Goldberg, George M. Moffett Professor of Agriculture and Business, will discuss the role of the worldwide rise in food prices in ending the recent economic boom, and suggest some policy changes that might correct the imbalance. Hendrik S. Houthakker, professor of economics and former member of the President's Council of Economic Advisors (1969-71), will provide perspectives on the current energy shortage, both long and short-term and with respect to U.S. economic relations with the rest of the world. Otto Eckstein, professor of economics and member of the faculty of public administration, will conclude the discussion by offering the macroeconomic viewpoint on how to adjust to the changing economy. He, too, has been a member of the President's Council of Economic Advisors (1964-66).

"Harvard Comes to Florida" will begin early in the afternoon with the two panels, followed by the reception and dinner for President Bok. After his speech, there will be a question and answer session in which everyone is invited to participate.

All HMS Alumni and guests are welcome. For complete details and registration forms, write Eugene Flipse '43B, General Chairman, Harvard Comes to Miami, 5513 Merrick Drive, Coral Gables, Florida 33146

Bicentennial Tapes Presented to Countway

Complete tape recordings of the International Bicentennial Symposium have been presented to the Countway Library in memory of the late Paul Dudley White '11, who addressed the meetings entitled, "International Bicentennial Symposium: Medicine and Surgery in America: The First 200 Years: Prologue 1976." The Symposium was held 21 October 1973 at the Boston Museum of Science.

The presentation was made 30 November 1973 by Edward G. Toomey, M.D., chairman of the Bicentennial Symposium, to Richard J. Wolfe, director of the Rare Books Library at the Countway.

"It was thought fitting," Dr. Toomey said, "that the continuing story of the development of excellence in patient care, teaching, and scientific research be told in Boston and in Massachusetts and that the revitalization of the highest ideals in medicine and science begin for the Nation in this city and in this state, as we approach the nation's 200th anniversary, a destiny-endowed time and a compelling opportunity for American medicine and science."

The tapes, he continued, will receive special treatment to preserve them at the Countway Library and will be available as resource materials for physicians, other scientists, and students in this country and abroad.

Management Program for Health Professionals

The Harvard Business School announces that the 1974 Program for Health Systems Management will be held from 6 June to 26 July 1974. Senior managers from the health care system or an allied area are cordially invited to apply.

Now in its third year, the intensive six-week program places primary emphasis on expanding the management abilities of high-level health executives and on broadening their understanding of the health care system as a whole.

The Program for Health Systems Management is sponsored by the Harvard Business School, the Harvard Medical School, and the Harvard School of Public Health and taught by their faculties.

Last year, five HMS alumni participated in the program. They were: M. Eugene Flipse '43B, director of health services at the University of Miami; Loren R. Mosher '61, chief of the center for studies of schizophrenia at the National Institute of Mental Health; Grant V. Rodkey '43A, assistant clinical professor of surgery at HMS; John J. Ross '56, associate professor of pediatrics at

the University of Florida; and August L. Stemmer '55, president of MeDatran. According to Dr. Rodkey, "It was an extraordinary experience; I know that I will never be the same again."

The principal teaching mode is the Harvard Business School's famed case method; curriculum topics include financial management, organizational issues, the health delivery system and its environment, operations management and computer-based systems, and policy and strategy.

Alumni interested in applying should write to the Program for Health Systems Management, Harvard Business School, Boston, Massachusetts 02163.

Promotions

Professor

John R. David: medicine
Claes H. Dohlman: ophthalmology
Irwin M. Freedberg '56: dermatology
Hermes C. Grillo '47: surgery at Massachusetts General Hospital
George L. Nardi: surgery at MGH
David G. Nathan '55: pediatrics
Richard E. Wilson: surgery at Peter Bent Brigham Hospital

Clinical Professor

Roman W. DeSanctis '55: medicine

Associate Professor

Leonard S. Bushnell: anesthesia at Beth Israel Hospital
Kurt J. Bloch: medicine at MGH
Nathan P. Couch '54: surgery at PBBH
David H. Katz: pathology
Alfred P. Morgan: surgery at PBBH

Associate Clinical Professor

James W. Etherington; operative dentistry
Richard A. Field '50: medicine

Assistant Professor

Debajit K. Biswas: oral biology and pathophysiology
Louis Burke: obstetrics and gynecology at BIH
David E. Drum '58: radiology at PBBH
Harvey Eisenberg: radiology at BIH
Kenneth M. Janis: anesthesia at MGH
Joan C. Kaplan: microbiology and molecular genetics
Inder V. Malhotra: anesthesia at BIH
Alix Mathieu: anesthesia at MGH
Shao-Yao Ying: anatomy

Assistant Clinical Professor

Hathorn P. Brown '43A: surgery
T. Corwin Fleming '56: neurology
Ralph G. Hirschowitz: psychiatry
Burton F. Jaffe: otolaryngology
L. Paul Lustig: prosthetic dentistry
William R. MacAusland, Jr. '47: orthopedic surgery
Robert N. Pilon: anesthesia
Ira Sherwin: neurology
Robert L. Shirley '60: obstetrics and gynecology

Principal Associate

Larry D. Boyd: psychiatry (psychobiology)

Principal Research Associate

Madhukar A. Pathak: dermatology (biochemistry)

Appointments

Associate Professor

Warren E. Grupe: pediatrics at The Children's Hospital
Stephen J. Miller: preventive and social medicine at the Affiliated Hospitals Center

Assistant Professor

Edward R. McFadden, Jr.: medicine
John R. Murphy: microbiology and molecular genetics
Roy D. Strand: radiology at TCH

Assistant Clinical Professor

Joseph Yacavone: dental edology

Lecturer

Noel Guillozet: pediatrics

Boston City Hospital: Part I

by Franklin H. Epstein, M.D.

Former Director, Thorndike Memorial Laboratory

In February 1973, the trustees of the Boston City Hospital voted to change the historic relationship between Harvard and the City Hospital and to ask Boston University to assume sole responsibility for all professional services at the hospital, thus bringing to an end 150 years of close and productive association between the Boston City Hospital and the Harvard Medical School. Though the decision had been foreseen and feared by many in the Harvard services of the Boston City Hospital for years, it still came as a stunning shock and a grievous disappointment to members of the Harvard Medical Unit and the Thorndike Memorial Laboratory.

How did this come about? Why should the city of Boston have turned its back on the unparalleled academic record and world-recognized contributions of the Harvard faculty? There were several factors in the denouement.

A steady decline prevailed over many years in the in-patient population at the hospital. This contrasted with a well maintained out-patient population that was, however, increasingly scattered among neighborhood health centers, supported by the faculty of all three medical schools and funded largely through federal and city funds. The medical services of Harvard, Boston University, and Tufts were reduced to three wards apiece, averaging not more than 60 patients. The surgical services were even more impoverished, requiring external rotations in order to provide adequate training for surgical residents.

The geographical proximity of Boston University Medical School to the City Hospital and its increasing influence in hospital affairs. Many in the faculty and administration at Boston University candidly admitted prior to the board's decision that the natural direction of expansion of the Boston University Medical School was to incorporate the clinical services of the City Hospital into a unified administrative structure. Ironically, these ambitions were aided when, with the agreement of Harvard, the direction of the Radiology Service, the Obstetrical Service, and the Pathology Service, were one by one transferred to Boston University in order to strengthen that school's teaching program. Psychiatric outpatient treatment in the Dorchester-Roxbury area was declared to be within Boston University's catchment area. The former director of the Boston City Hospital was employed by Boston University Medical School and logically, a close working relationship developed between the dean of BUMS and the administration of the BCH.

The world renown of the Harvard services during the 50 years that followed the establishment of the Thorndike Memorial Laboratory engendered a keen sense of competition that was often friendly and usually intense. Because of Harvard's pre-eminent role in research and national prestige, stress was created among the faculty of the three schools at the hospital. Harvard's assumption that it deserved the leadership role in medicine and surgery at the City Hospital engendered bitter talk of "Harvard arrogance" in the hospital administration, the trustees, and the Boston University faculty, that had deep roots and would surface later.

The final events leading to the decision of the trustees occurred with startling suddenness in an atmosphere of crisis and confusion. The crisis was precipitated by the announcement by Mayor Kevin White that the budget of the Department of Health and Hospitals had to be cut by $14 million dollars. By now, this was familiar in the history of Boston City Hospital politics; such crises had always been resolved through compromise on both sides and the City Hospital had continued with little change. This time, however, the Mayor was serious.

It was literally an impossible task to reduce hospital expenditures by that amount and retain the three schools without closing the hospital. Debates arose on all sides: a reduction in services would simply mean a reduction in revenue, since 80 percent of hospital costs were borne by third parties, including Medicare and welfare. Others contended thatr real reduction of costs could only be achieved by eliminating services which produced little revenue, such as the outpatient community health centers and the obstetrical and pediatric services. However, it was politically unwise or impossible to eliminate these.

Site upon which Boston City Hospital stands today.

The Boston City Hospital, 1880.

Faced with an impossible task, the hospital administration was under intense pressure to demonstrate, in some highly visible fashion, that it was doing everything it possibly could to reorganize the hospital in order to save money. Accordingly, unification of the services was called for in order to eliminate "unnecessary duplication."

In actual fact, cost benefit analyses indicating the economies of a unified system in contrast with the three school system were never provided. It is possible that the additional expenses that derived from the triple medical and surgical services were more than counterbalanced by the additional faculty, services, and overhead income to the hospital provided by Harvard, and, to a lesser extent, by Tufts.

It seemed to the Harvard faculty that the critical decision for unification strengthened the hand of Boston University because the politically sensitive pediatric and obstetric services had been voluntarily granted to BU. Within a few weeks the decision of which medical school it was to be was rushed to a vote of the Board of Trustees under the deadline of the Mayor's budget. Harvard and Tufts University's were given 72 hours to prepare formal submissions to the board.

In the final vote of the Board of Trustees, which directed that the services of the hospital be directed by Boston University Medical School, it was also voted that both Harvard and Tufts be encouraged to stay at the City Hospital and to contribute to teaching and research. But despite public statements of reassurance, it rapidly became apparent that this would not be possible, at least in the traditional sense.

The Harvard house staff was to be dissolved. Intern applicants to the Harvard medical service for 1973-74 were immediately scratched from the Boston City Hospital matching plan list, and Boston City Hospital interns were selected from applicants to the Boston University service, together with a few applicants to the Tufts service. Assurances had initially been given that Harvard medical students could continue to have their Core Clinical Clerkship taught at the Boston City by Harvard faculty. Such instruction, however, could not be localized on the same wards throughout the year; the new administrative team voiced the fear that such wards might be identified as "Harvard wards!" The nurses on the Peabody wards, used to working together as a unit, were scattered throughout the hospital. The decision to eliminate the vestige of a Harvard house staff, so critically important in the undergraduate teaching of medicine and the maintenance of continued growth within a medical department, was the final and most important blow that forced the decision for the gradual departure of the Harvard department of medicine from the BCH.

The Harvard house staff at the Boston City Hospital on the Second and Fourth Medical Services considered themselves to be a special breed. They knew that they had "an impossible task" and they were proud of it. They came from all parts of the country, were reminded at frequent intervals of the heritage of accomplishment in the grimy walls and the overcrowded laboratories of the Thorndike. They took pleasure and pride in bringing the best of medicine, the highest science, and the greatest compassion to the poor of the city of Boston. They populated the country's departments of medicine when they left Boston but they never forgot where they had been trained. In 1973, as half a century earlier when the Thorndike opened, a glint of excitement came to the eyes of the best medical graduates in the country when they visited the City Hospital. Were they really interested in the science and the art of medicine in the tradition of a Peabody, a Minot, a Castle or a Finland? Were they interested, too, in the urban dilemma — the toughest American problem of the rest of their lives? Then they should come to the south of Boston — where Harvard had opened its doors to those in need. It seemed to those at the Thorndike that with the loss of the house staff, Harvard had lost its raison d'être at the Boston City Hospital. It had lost its growing tip, its flood of renewal, which for so long had permeated all of its activities.

In light of the above, during the summer of 1973, an ad hoc committee, chaired by President Derek C. Bok, decided that the Thorndike Memorial Laboratory should be transferred to the department of medicine at the Beth Israel Hospital. Accordingly, during the remainder of the 1973-74 academic year, several investigators will be moved in stages to this department of medicine across town while continuing some activities at the Boston City Hospital. Permission was granted by the Clinical Center Branch of the USPHS to transfer the activities of the Harvard Clinical Center to the Beth Israel Hospital where new facilities are being prepared to continue the ongoing research programs comprising this important center grant.

Boston City Hospital: Part II

by William V. McDermott, Jr. '42
Director, Sears Surgical Laboratory

Origin and Development

The history of the Boston City Hospital (BCH) has been documented in numerous ways and from varying viewpoints.[1,2,3,4] From the opening of the hospital in 1864 when five Harvard medical students served as the first house officers, through the subsequent decades when Dr. David W. Cheever played such a major role in the development of the institution to the founding of the Thorndike Memorial Laboratories in 1923, Harvard Medical School has been symbiotically involved with the hospital and the two institutions have shared both the prestige and the problems of over a century of involvement with municipal health problems.

Over the period, the tremendous academic accomplishments in the Thorndike Unit strengthened later by the Neurological Unit, The Channing Institute for Infectious Disease and the Sears Surgical Laboratories attracted young men of the highest caliber and motivation to the hospital. This was reflected not only in the growing international stature but in the internal esprit which, at all levels, expected and produced excellence in the intellectual environment which in turn was reflected in an austere but humanistic approach to the sick patient. In his classic monograph on "The Care of the Patient," Francis W. Peabody epitomized the remarkable combination of intellect and humanism in the statement that "the secret of the care of the patient is in caring for the patient." Even in the agonal phases of the institution, one has always sensed this unusual combination of academic excellence and clinical competence with ultimate application to human problems. Into this melange, Tufts Medical School projected, in 1915, its basic mission of primary medical care and worked with Harvard in the continuing development of the Boston City Hospital. Later, in 1930, Boston University Medical School, joined the scene and funneled much of its resources into the hospital. Thus, an amalgam was developed. Why did it for a time succeed so well and so inexplicably fail? The answer to the first part of the question is by now subject to the critical analysis of historical perspective.

Until the advent of increasing sources of third-party payments in support of medical care during the past three decades, a significant portion of our population could be classified as medically indigent and, in the urban areas, were dependent on the municipal hospitals that had flourished in most of our major cities. These citizens for a time represented a sizeable voting block and financial and political support developed for these institutions. It is interesting to review the address given at the dedication of the Thorndike Memorial Laboratory by the Honorable James M. Curley, then Mayor of Boston. In his memorable flowing prose, he commented, "I have always been intensely interested in the Boston City Hospital and its work and possibilities and have sought as far as lay in my official authority to foster its administration and augment its efficiency. Its expansion must keep pace with the growth of the city." Then in closing, "The dedication of the Thorndike Memorial is without any exaggeration, the most important event in the latter day history of Boston; its discoveries and achievements will interest all earth and add to the righteous pride and real glory of Boston."[5] More tangible results appeared as evidence of the interest of the City as a building program continued through the two decades preceding World War II.

The Neurological Unit officially moved into quarters in the Medical Building under the direction of Dr. Stanley Cobb. The distinguished history of this Unit has been described[1] and names such as Fremont-Smith, Lennox, Gibbs, Merritt, Putnam, Monroe, Denny-Brown and many others are part of medical history.

The Fifth (Harvard) Surgical Service was strengthened in 1955 by the Sears Surgical Laboratory and the Channing Institute for Infectious Disease was relocated at the BCH.

The contributions to the academic world by graduates of these units have been truly monumental and documented with pride and affection by Maxwell Finland 26[2]. As noted in a review of a study of the BCH by Stephen Miller, the tradition was well characterized by the phrase

Surgery then – Dr. Frank Lahey at left with arms folded

"From Purgatory to Olympus."[7] One graduate was asked by William B. Castle '21 if his tour at the City Had been worth it and received the slightly delayed but thoughtful and succinct reply — "Just!"

Decline and Fall

Following World War II, the impact of both private and governmental programs, which provided third party coverage for hospital costs, became apparent in a progressive decrease in the size of ward populations both in private and public hospitals. With this occurred a perceptible decline in public interest both in the citizenry and in the government in municipal hospitals throughout the country. During the decade, 1961–70, the in-patient census of the Boston City Hospital continued to fall but at a less precipitous rate, and the ambulatory responsibilities actually increased somewhat. Despite the fact that the net deficit of the hospital was less than 12 million dollars in 1971 compared to 15 millions in 1961, there was a mounting clamor to reduce costs accompanied by strong public reactions by the professional staff. For a time, everyone seemed to become involved in the act in one way or another. Accuracy was not the common denominator of most of the stories and was exemplified by Jonathan Kozol's published testimony that infants born at Boston City Hospital have twice the risk of death within the first four weeks of life as do children born at the Massachusetts General Hospital — an institution that closed out its obstetrical service in 1953. Regardless of motivation or intent, disinterest rose and federal support for a number of programs dried up. For years, efforts had been made by the professional staff to develop a building program and an administrative reorganization which could have prevented a mounting deficit and provided an intermingling of the more affluent with the residual medically indigent. This was not to be and when labor contract settlements and decreased income resulted in the projection of a deficit for 1973 in the range of 26 millions, it was clearly too late. The long-range plans over which so much effort, time, thought, and money had been expended in 1968 had never been and now never would be implemented.

The classic City Hospital pattern of crash decisions and crisis planning again came into view. Among other things, the "inefficiency" of three medical schools functioning in the same hospital was pointed out as it had been recurrently for years — with some degree of truth behind the broad allegations. This had always been a favorite political diversionary tactic when any crisis arose. Both Harvard and Tufts felt that support from all three Universities was essential to the hospital, but for some time faculty members at Boston University had emphasized the need of one-school control and stressed the importance of the geographical contiguity of University Hospital.

The three medical schools were asked to submit plans which had to be formulated *and* reviewed in less than a week. As Dean Ephraim Friedman of Boston University summarized the developments — "On February 28, 1973, the Board of Trustees of the Department of Health and Hospitals of the City of Boston decided, after months of negotiation, to vest with the Boston University School of Medicine the responsibility for professional staffing of the Boston City Hospital."[6] The administration and faculty of the other two schools had not been privy to these negotiations and it was a foregone conclusion that no independent general medical or surgical unit would be permitted to either Harvard or Tufts after June 30, 1973 which effectively ended 109 years of association between Harvard and the BCh.

The Board also announced that by July, 1973, the capacity of the hospital would be limited to 500 beds, a ceiling accomplished by cancelling elective admissions; this has certainly been effective since recently the census has been well under 400 for the first time in history. Mr. Leon White, the newly appointed Commissioner of Health and Hospitals announced that excess patients would be accommodated in other hospitals in the city. Exactly how effective this forced dispersion of the medically indigent will be is unpredictable and how the quality of their medical care will be affected will probably not be measurable.

The course, as charted, appears headed towards a progressive reduction in in-patient services since the changes as described have not yet accomplished the firmly maintained goal of the municipal government — a reduction in annual expenditures by the entire Department from $68 to 54 millions. Since political expediency does not permit closing of Long Island or Mattapan Hospitals or a significant reduction in ambulatory services, the final crunch will clearly be borne by the BCH itself. In this narrative review of events, no further speculation is indicated since the future will become self-evident as it becomes the present.

–and now.

The Harvard units at the BCH faced different problems and the remainder of this article will deal with the various solutions defined by joint discussions of the Faculty at the BCH and the Administration of the Harvard Medical School.

Financial support by Harvard University had grown to a total of 8.2 million dollars in endowment funds, and over 3 millions annually from other sources; since all of these monies are linked to the existence of Harvard services at the BCH, they will ultimately be used to support patient care, teaching, training, and research elsewhere, a result neither willed nor desired by the University or its faculty.

Tufts announced a total withdrawal and perhaps will define its position and plans independently.

Conclusions and Beginnings

Of all the Harvard units, the Second and Fourth Medical Services and the Thorndike Memorial Laboratory have had the most impact on science and education; details of these enormous contributions in people and in ideas have been given elsewhere. Linked as they were, so intimately to the BCH, the Second and Fourth Medical Services ceased to exist on July 1, 1973. The recently appointed director, Dr. Franklin Epstein, accepted the position of chief of medicine at the Beth Israel Hospital and some of his staff relocated with him. Others have remained at the hospital, providing supervision for the house staff who had little or no choice but to remain for another year in an amalgamated program. As these members of the resident and visiting staff gradually take other positions, little or no vestige of Harvard's prestigious clinical services will remain. Various special funds supporting professorships, lectureships, etc. will be gradually dispersed throughout Harvard Medical School. The activities of Thorndike Memorial Laboratory, by a decision of an ad hoc committee chaired by President Bok, will eventually move to the Beth Israel Hospital when adequate facilities now under construction have been completed and the research facilities and space in the old Thorndike Building continue under hospital direction and different personnel. It will be difficult, if not impossible, for the past and present staff to accept emotionally, the forced separation of the previously inseparable Thorndike and BCH. It is always hard to grasp the fact that institutions, no matter how ancient and venerable, are not immortal, were created by man, and can be destroyed by man.*

The situation of the Fifth (Harvard) Surgical Service and the Sears Surgical Laboratories was somewhat different. At the time of the debacle, the teaching and training programs, as a result of a steady shift in emphasis over ten years, were already committed to a broad base that involved five other hospitals — the Cambridge, Faulkner, Manchester VA, Mount Auburn, and New England Deaconess. Thus the entire structure could be continued with very little dislocation and the decision was reached to move the Cheever Professorship out of the BCH and relocate the department offices and personnel in the Cancer Research Institute of the New England Deaconess Hospital. All of the newly appointed interns and the existing resident staff elected to join the new program which has now been in active and satisfactory operation since July 1, 1973. The Sears Surgical Laboratories will continue to function under Harvard direction at the BCH, although some units will move to the New England Deaconess and personnel will continue with some responsibilities for patient care and for the few interns and residents who will continue for the moment to rotate into selected positions. At the moment, it would be as foolish to predict the future of these activities as it would the future of the hospital itself.

Neurology and Neurosurgery remain as the sole clinical departments identifiable as under Harvard direction, since Psychiatry has ceased to exist as a university department. The specialty services will probably face future financial stringencies prior to the general services so the long-term future in these isolated positions is uncertain to say the least.

The Channing Memorial Laboratory for Infectious Disease is another unit of academic prestige and excellence. At the moment, the personnel continue to provide their superb services to the patients at BCH, but will probably relocate eventually in a more central position in the Harvard galaxy and continue as an identifiable Harvard unit.

This endeth the lesson. From the Decalogue of Medicine as written in the "autobiography" of the Harvard Medical Unit — Honor they Resident and thy AR for their doctrines are good ones; thou shalt not take the name of thy head nurse in vain; thou shalt diligently fill in the yellow sheets with little boxes that they shall not remain empty in the sight of thy leader. These and the remainder of the Decalogue, like the voice of the turtle, shall no longer be heard in the land but voices of memory from the generations of Harvard men and women will keep alive the marvelous sagas and tales which could only have happened at the old Boston City Hospital.

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* Dr. Alan S. Cohen recently was appointed director of the Thorndike Laboratory by the Boston City Hospital. This has historical precedent in the development of two and then three lines of the Papacy at the time of the flight of Clement VII to Avignon. Then in the 16th century in Ireland, it was not unusual to have two titular clan leaders; when the armies of Elizabeth finally conquered Blarney Castle, The McCarthy escaped to live with the clan while the newly installed owner of the castle was referred to as The Queen's McCarthy.

Boston City Hospital: Part III

by Edward H. Kass, M.D.
Director, Channing Laboratory

Each of us has perceptions of what happened at the Boston City Hospital, and why. I shall try to outline mine. What happened must considered against the backdrop of the problems of cities and the problems of health delivery systems, particularly as they affect large urban centers. Thus, not only are costs rising, and demands expanding, but also, in municipal hospitals, the financing in part is coming from cities that are plagued with the well-known cycle of problems: inadequate revenue, increasing demand for human services of all kinds, reluctance of physicians to live and practice in slum areas, decaying physical plants, and a political system that is too often capricious. The entire health delivery system is undergoing reappraisal, but the municipal system is particularly feeling the pressures of the times.

Among the special features of our present system of health care as it relates to city hospitals is the problem of the working poor, or, more euphemistically, the medically indigent. These are people who are earning their own way, and are neither eligible for, nor want, welfare. But because many of these individuals are not covered by any form of insurance for hospitalization or other medical care, they are unable to pay for catastrophic illness. In today's anomalous situation, if a serious medical problem arises, the best thing such people can do is to go on welfare.

How does the problem of the working poor affect the BCH? Approximately 70-75 percent of inpatient costs at the BCH have been reimbursable from third party sources. About half of these costs are paid by Medicaid, and the remaining 20-25 percent is distributed among Medicare, Blue Cross, and other insurance programs. A small amount of the uncollected residue may be collectable from third party sources, but most of the difference between inpatient costs and third party collections is due to the care given to the working poor. In the case of ambulatory care, the gap is still greater between services supplied and costs that are recoverable from third party sources, since coverage for hospitalization is more extensive than coverage for ambulatory care. This, and the rapidly declining number of physicians practicing in slum areas, accounts for the increasing use of ambulatory care facilities. For example, the combined use of the BCH outpatient department, emergency floor, and neighborhood health centers accounted for over 600,000 visits last year.

The most important function of the municipal hospital has been to supply free medical care to those who otherwise could not afford it. As Medicaid has taken hold, welfare recipients have received reasonable coverage in any institution. Many Medicaid-covered patients have begun to seek care in institutions other than the city hospitals. Now that beds have become available in many urban hospitals, welfare patients are finding themselves welcome in a way that was uncommon a generation ago. On the other hand, the working poor are not always free to choose. Lacking any means for payment, they must seek out the City Hospital. Since the working poor are primarily responsible for the deficit experienced by the BCH, one solution has been to begin billing them, and some have been taken to court for not making some arrangement for paying their own way.

There is another effect of the City Hospital that may have been overlooked. The BCH has served as a safety valve that has made it possible for other hospitals in the community to come closer to efficient and profitable operation. If the City Hospital provides care for those who cannot pay, the other hospitals are free of this burden. However, taking care of those who cannot pay is as expensive for the BCH as it is for other hospitals, so the City Hospital inevitably looked less efficient, and was. The special problems of the BCH in relation to its social functions were not always recognized. Some have tended to regard the inefficiencies of the municipal hospitals systems, not as an important feature of the present system of medical care, but as a regrettable, but understandable, consequence of the political inadequacies of city machines.

I do not wish to minimize the problems of achieving more efficient administration under the conditions that obtain, or the need for capital improvement that probably would increase efficiency or provide other ways of dealing with costs. I simply want to stress that most of the financial problems of the BCH center around who is going to take care of the working poor, and will not be solved by the most cost-conscious of administrative efforts, desirable as these may be.

A plan has been initiated whereby the Hospital will be reduced in bed capacity to 500, and when this limit has been

Horsedrawn ambulances outside BCH, 1905.

exceeded, other hospitals have agreed to receive the excess, regardless of the patient's ability to pay. This will work up to a point, because the numbers to be accommodated by other hospitals will be small, and because an empty bed costs about 75 percent as much as a full bed, so the excess cost of the patient to the recipient hospital is small. However, to the degree that the BCH cuts down its maximum bed capacity further, the squeeze to the other hospitals may become more severe. It will not do to argue that the BCH may slowly be lowering its census anyway, through market forces. Those patients who are voluntarily going elsewhere are the ones with third party coverage, and not the working poor, so the BCH may be lowering its bed capacity, but is not likely to be reducing its deficit in proportion. This may take a while to be tested, but it seems unlikely to me that the recent events will in fact reduce the budgetary deficit by as much as the public has been led to expect.

A few things about the BCH itself are worth restating. As Dean Ebert has pointed out, at the time that he, and a few years later, I, were house officers there, the number of patients in the hospital hovered at around 1300, excluding those in the Long Island Chronic Diseases Hospital and in the Mattapan Sanatorium. There was still limited activity in the city-operated health clinics, but these clinics had fallen into disrepair, from their once proud status as a model for the nation.

In recent years, under pressure from the community, and assisted by federal, state, and local funding, Boston once again began to assume leadership in the creation of neighborhood health centers. About 600,000 visits annually have been occurring in the ambulatory components, while the census in the Hospital has declined to less than half its former peak levels.

Perhaps the most important feature of the declining bed census is that the average length of stay of patients has been halved. This has been due in part to advances in the treatment and understanding of disease, and in part to the availability of more nursing home, chronic disease, and convalescent facilities.

Another feature has been the remarkable decline in the incidence of certain

BCH office, 1901.

communicable diseases, so that the average age of patients has steadily increased, and the disease spectrum has increasingly reflected the effects of chronic disease and acute complications of chronic disease, rather than of acute disease.

At the same time, important societal changes have been taking place around the Hospital, altering its constituency. In earlier years, the underprivileged who were served by the Hospital were most frequently Irish immigrants who had fled the great famine, but there were also Italian, Jewish, and other minority groups. All shared the sense of the time that hospitals were no longer pesthouses to which people came to die, but were new institutions of healing and hope from which would emanate the means for curing disease. The Hospital became the focus of the social service system of the time, and no political figure considered any act that would suggest less than full support for the Hospital.

However, the immigrant underprivileged became more affluent, moved to other parts of the city or to suburbia, and were replaced by new immigrants; Blacks from the South, Puerto Ricans, and most recently, Haitians. Only the elderly remained behind to recall the populations of the past. The new constituency is younger, less hospital-oriented, not yet fully politically articulate, and is not enthusiastic over the fact that much of the power structure of the city and of the Hospital still resides in the older political forces.

In the atmosphere of the '20's and '30's, the hospital's growth was rapid and its support, while never lavish, was consistent with the times. In this atmosphere, the Thorndike Memorial Laboratory, the Sears Surgical Laboratory, the Neurological Unit, the Mallory Institute of Pathology, and other units were either created, refurbished, or renewed, all under the leadership of Harvard faculty. The citizens of Boston could be secure in the knowledge that no better physicians were available anywhere in the world, than in their Hospital — and it was their Hospital.

There were many unmet problems. The services were not equal in their support or in their functions, but there was a great deal of homogeneity and a remarkable esprit. Small wonder that young men like myself came from all over the world to train here and to sit at the feet of the extraordinary physicians who were combining the best of medical knowledge with new investigations, all brought together at the bedside.

The Harvard units were acknowledged to be in the forefront of this surge, not just in the Hospital, but nationally. To me, an important element in Harvard's success was that the Harvard departments at the BCH were administratively

equal and not subservient to other Harvard departments at other hospitals. There was no sense that the BCH was secondary or a satellite to any other hospital. The friendly rivalry among the four Harvard departments of medicine was a rivalry of equals, and gave enormous strength and stimulation to the school and to the community.

However, as time began to decimate Harvard's leaders at the BCH, there was not always a commitment by the University, and sometimes even by the Harvard staff at the Hospital, to replace them with men of comparable stature or to maintain their departments as Harvard units. In some instances, as in the case of Obstetrics and Gynecology, Harvard agreed to give up its leadership in the department in response to a plea from a sister institution. So, over a period of almost 20 years, Harvard units, which had been responsible for over two-thirds of the medical functions of the Hospital, declined to the point of being responsible for less than one-third of its medical functions.

There were many reasons for this decline in Harvard's dominance, not all of them complementary to those who made short-term rather than long-term decisions. However, it should be clear from the history of these decisions that no one person could possibly have accounted for this slow, steady stream of actions that undermined Harvard's position at the BCH, although a few seem to me to have special distinction in this sphere. Among these were the increasing attention to the ambulatory patient, to integrating preventive and social concepts with clinical practice at the bedside, the changing population base, the increasingly difficult financial problems of the city, the decaying physical plant, and the severe administrative problems. These and other considerations were looming larger and larger in the total medical care problems of the Hospital and of the city. And neither the BCH nor our colleagues at other Harvard institutions were generating as much response as was needed.

The immediate precipitating events that led to the withdrawal of the Harvard Departments of Medicine and Surgery have been described. From the point of view of simple efficiency, and of regional planning, there is little doubt that University Hospital and Boston City Hospital can integrate certain services, and realize some economies and efficiencies. The degree to which these economies are realized, however, is not yet certain, and the costs in terms of quality of patient care are by no means clearly charted. It is a bold experiment that needs much watching and analysis before its effects can be determined.

Contrary to the expectation of some, I do not see major changes occurring in the budgetary problems of the Hospital, because I see no way that the working poor will be dealt with more effectively in the new framework. Given the decaying physical plant, and the statutory maximum census, I would guess that the decline in bed occupancy will continue for some time, although perhaps at a slower rate as the asymptote is approached.

What does this mean to Harvard? Clearly, Harvard's teaching beds have been reduced in number, and some of Harvard's plans for the future must be re-examined. If however, Harvard learns the lessons that are being thrust at us, this will not all have been in vain.

First, Harvard has not related itself to the community as completely or as effectively as is necessary. Some important steps, such as the Harvard Community Health Plan, the East Boston Program, and many of the health centers operating under hospital sponsorship have been taken. But these are not enough to assure a constituency that is loyal to Harvard's institutions or that will supply a population base sufficient to assure that its hospitals are being used efficiently.

Second, major new areas of investigation require Harvard's quality of leadership. We need to know more about preventing chronic disease, more about why the communicable diseases have been disappearing as causes of death, more about who uses our facilities and why, more about how to teach and to understand disease in an ambulatory setting, more about how people become ill and how they respond to illness, more about how the existing medical facilities are utilized, and so many other problems that have hitherto not received much attention from medical scientists. To supply answers will require the development of a new brand of physician, teacher, and investigator, skillful in clinical practice and in methods of investigation, who can function at preventive and therapeutic levels and in the transmission of these skills to medical students and to medical health workers.

If the problems of the BCH will have nourished at Harvard a still greater awareness and involvement with these issues than has characterized the past, it will all have been worth it, despite the pain.

An early motor-powered ambulance.

The Present Illness

by Lawrence R. Berger '74

"Medicine is a social science; politics is nothing but medicine on a large scale." Thus wrote Rudolf Virchow in 1848. One hundred and twenty-five years later, *The Present Illness*, "an independent publication of the Harvard medical area," appeared as a journalistic expression of Virchow's belief. From the first issue of the newspaper in January 1973, its articles and editorials have sought to reveal the nature and extent of the interaction between politics and medicine.

Genesis

The Present Illness arose from the most humble of circumstances. The two current editors, both medical students, were lamenting the vacuum of political activity at Harvard. Political meetings that formerly drew crowds of concerned people had dwindled to groups of three or four, all members of a shifting, but familiar, constituency. Yet the issues with which we were all so concerned were none-the-less urgent, none-the-less important. What could be done to reach a larger audience? Publish, of course! Not rhetorical leaflets — whose vocabulary alone provided an excuse for the unconvinced to "turn off" and turn away — but a legitimate newspaper, printed on decent paper, well researched, and sprinkled with a sense of humor.

Naturally the first problem was to decide on a title. "Chief Complaint" was an early suggestion; that sounded too negative. "System Review" had a hearty political ring to it, but was too sweeping in scope. *The Present Illness* was just right: an identifiable medical flavor, with the message that all-was-not-well in the land of Hippocrates.

Funding was the next major concern. Fortunately, photo-offset has accomplished for the radical press what Gutenburg accomplished for the Bible; quality printing at a reasonable price! By drawing on personal funds it was possible to finance the first issue. Once in print, contributions from sympathetic readers could be solicited. To date, there has been no necessity to accept advertising, request aid from the Student-Faculty Committee, or sell our medical textbooks in order to continue publishing.

One unexpected dilemma had to do with crediting the staff. Should we put our names on each issue, thereby running the risk of being accused of "making a name for ourselves" by muck-raking individuals? Or should we remain anonymous, and be accused of shunning editorial responsibility for personal security? Editorial responsibility won, after some vacillation. Each issue now mentions the names of the editors, and of all contributors who agree to be credited in print.

Precedent

Harvard has had no dearth of politically-minded medical graduates. Yet a search of the Countway Library archives failed to reveal any previous publication by medical students that appeared on a regular basis and was devoted to issues of politics and health. In the spring of 1969, however, such a publication did appear: *The Red Nucleus*. Mimeographed on the same machine that produced the lecture service, this newsletter was spawned during the neuroanatomy block of the first-year curriculum. The neurologic origin was reflected in both the name and subheading: "The Red Nucleus, lying deep within the established white matter, relaying vital information outside the traditional pathway." Actually, political material began appearing in lecture service outlines earlier that year; a biochemistry lecture concluded with quotes from Che Guevara and Mao Tse Tung for example. Expanding the political content and eliminating the distracting formulae and pathways was a logical next step. Topics included in *The Red Nucleus* included the Vietnam war, the core curriculum, the Affiliated Hospitals and the Roxbury Tenants of Harvard Association, the A.M.A., and the drug industry.

Like the editors of *The Present Illness,* the staff of *The Red Nucleus* were largely motivated by frustration. As Don Nortman wrote in the 1972 *Aesculapiad:*

Many of those who took part had found lectures often poorly taught, oriented mainly toward research and academic medicine and often overlooking major public health issues and common diseases. The mold into which we saw ourselves being poured was that of an elite, academic clique, responding slowly if at all to the outside world. Many felt themselves thrust into an alien system over which they had little control or power to change. Added to this was the polarization of the class as a result of the strike in the spring of 1969, and the resultant loneliness of those in the minority.

Often criticized for lack of references, radical emotionalism, and diffuse rhetoric, each new issue was sought after by faculty and students eager to read about the latest targets of the wrath of *The Red Nucleus* collective. Publication ceased in the fall of 1969, a victim of other political commitments and Human Biology II.

Present Illness Philosophy

The principles guiding editorial decisions are few, but invariable: support allegations with complete documentation, quote in context, and make the editorial position explicit. Topics are chosen in order to raise general political issues, not to embarrass individuals or individual departments. Thus, *The Present Illness* contained lengthy discussions of the pharmaceutical, food, and tobacco industries in the issues on Drs. Ebert, Stare, and Huber, respectively. The details of each lead story were of course not neglected, but were used an an entrée to the discussion of more universal political issues.

Corporate influence over the health of the American people is a major focus of attention. Financial conflict of interest is inevitable in medicine as long the profit motive exists in the health care system. Patient care and the public health can be

victims of individuals seeking research funds, personal financial gain, or positions of power and prestige. At the same time the economic, social, and political implications of medical decisions are often not considered, or at least not made explicit. Pointing out these implications, calling for ethical behavior in regard to corporate intervention in medicine, and spot-lighting politically controversial issues in the Harvard Medical Area, are the primary functions of *The Present Illness*.

Content

Medicine and the military, the first issue of *The Present Illness,* documented the use of medical skills as a "military-political weapon" for the use of the U.S. military in counter-insurgency operations, military personnel control, and psychological warfare. Excerpts from *Military Medicine* magazine ("The official journal of the American Military Surgeons") were contrasted with two codes of medical ethics: the 1948 Declaration of Geneva, and the AMA Principles of Medical Ethics. It was hoped that readers eligible for the doctor draft would consider non-participation with the Pentagon after reading the issue.

February's *The Present Illness* featured *Washington Post* reporter Morton Mintz's article on Dean Ebert's renewed involvement with Squibb Pharmaceuticals. Dr. Ebert had been criticized in 1969 for accepting a position on the company's board of directors. Four years later he appeared as a consultant for Squibb in support of Mysteclin-F, a combination antibiotic. Mintz's article provided the opportunity to discuss the role of the drug industry in American medicine. An editorial called for medical schools to establish standards of ethics in regard to conflicts-of-interest among its faculty.

An issue on union organizing efforts in Boston hospitals in March was followed by the most ambitious effort of *The Present Illness* to date: a six page issue on Dr. Fredrick Stare, chairman of the department of nutrition at the Harvard School of Public Health. The nutrition department is funded heavily by food industry dollars. A paid consultant of many food companies and trade associations, Stare has testified before numerous Congressional committees on their behalf. *The Present Illness* ran an editorial pointing out that:

Food is now a $120 billion a year industry. Food companies are a new political power, with considerable influence over federal and state agriculture departments, the F.D.A., and even Congress... The need for an independent observer — and critic — of the food industry, and of federal agencies dealing with food, is more urgent than ever. If the chairman of the nutrition department of a school of public health does not assume the role, who is to be a consumer advocate?

The federal budget in the health field was the topic of the last issue before summer vacation. The termination of federal research fellowships was shown to be only one aspect of the Nixon administration's undermining of health activities in the U.S. Cutbacks in mental health, care of the elderly, and medical education were constrasted with increased expenditures for defense and foreign military aid. Ironically, the in-

Editorial in February, 1973 issue.

EDiTORiAL

In a letter to Dr. Ebert, the Dean was asked to comment on the following questions raised by his Mysteclin testimony:

(1) Why did you choose to represent Squibb on the issue of a drug of at best controversial merit?

(2) Have you personally done research--laboratory and/or clinical--directly related to Mysteclin?

(3) What was the content of your testimony?

(4) May we read a transcript?

(5) What is your response to the accusation that your working for Squibb as a research consultant constitutes a conflict of interest?

His reply is adjacent. Space limitations prevent a full discussion of Mysteclin. However, Dr. Ebert's reply to question #5 deserves further comment.

Clearly, the potential for abuse exists whenever a person "serves two masters." If the standard for conflict-of-interest were to be the individual's assessment of his/her own objectivity, a system of ethical behavior would rest on a precarious foundation indeed.

While an individual's integrity can conceivably transcend any financial ties he/she may have, the picture revealed to the public is inevitably viewed in a skeptical, even distrustful, manner. In fact, the credibility of the entire medical faculty is called into question (Do all faculty members have ties to drug companies?).

What should be done? Requiring that all faculty members publicly disclose their corporate affiliations (consultant, board member, holder of research grant) is a logical place to begin. The establishment of an independent medical school committee to review questions of conflict of interest--and other matters related to medical ethics--would also be desirable. The committee would establish ethical guidelines, as well as review individual cases.

Justifiably or not, medical schools have traditionally viewed themselves as standards of excellence in clinical practice, as well as in medical research. Should not a commitment to standards of excellence in questions of medical ethics also be accepted as a fundamental tenet?

—Larry Berger

The Present Illness

An Independant Newslattar from tha Harvard Madical Area — Number 7- October, 1973

Researchers accept tobacco industry $$

CAUTiON: HARVARD MAY BE HAZARDOUS TO YOUR HEALTH

HARVARD RELEASE, 12/27/72 = Tobacco Institute Pamphlet ≠ SURGEON GENERAL, 1972

"A five year investigation into pulmonary and cardiovascular diseases has been launched by the Harvard Medical School with a grant from the following tobacco companies: American Brands, Brown and Williamson, Larus and Brothers, Liggett and Meyers, Lorillard, Philip Morris, R.J. Reynolds, the U.S. Tobacco Co., and Tobacco Associates, an association of tobacco growers.

For many adults, cigarette smoking is one of life's pleasures. Does it cause illness--even death? No one knows.

The case against smoking is based almost entirely on inferences drawn from statistics and no causal relationship has actually been established. Many respected scientists find that cigarette smoking has not been shown to cause any

CORONARY HEART DISEASE: Cigarette smokers have higher death rates from coronary heart disease (CHD) than nonsmokers. This relationship is stronger for men than women. Cigarette smoking markedly increased an individual's susceptibility to earlier death from CHD. Cessation of smoking is associated with a decreased risk of death from CHD.

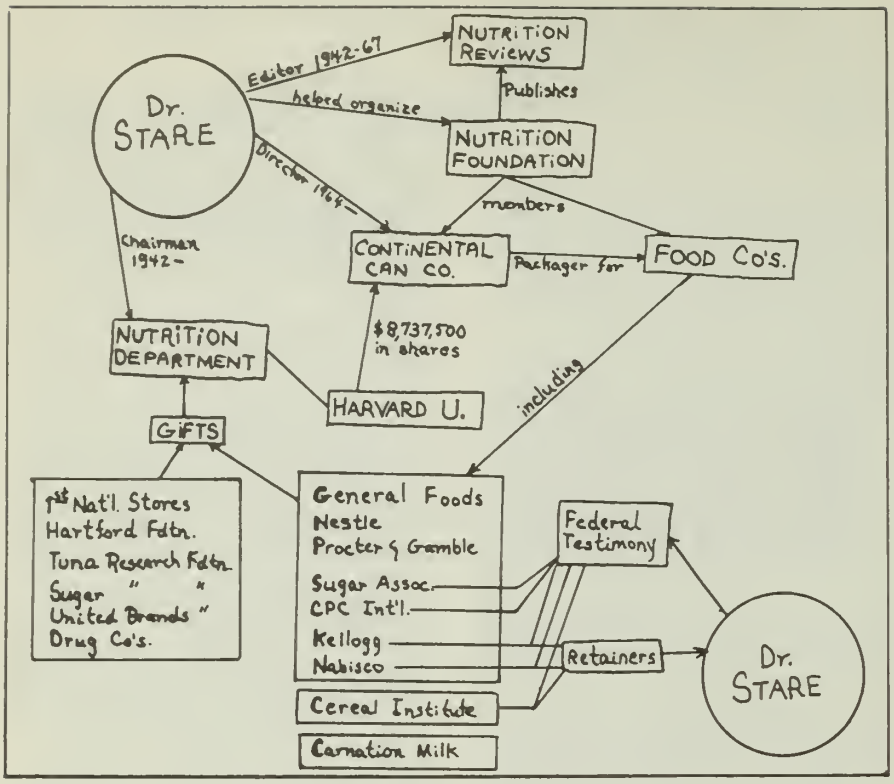

Diagram outlines Dr. Stares activities, April 1973 issue.

crease in defense research and development amounted to $500 million, equal to the amount cut from the National Institutes of Health.

Publication resumed this September with an issue entitled "A Greek Tragedy." Prompted by semi-official visits of Harvard physicians to Athens over the last two years, *The Present Illness* reviewed the political situation in Greece, the nature of the Greek junta (since over-thrown by a still more rightist faction), and the trial of a Greek pediatrician, Dr. Stefanos Pandelakis, who had been tortured for his efforts to end American support for the regime of the colonels.

Our current issue (whose headline reads: "Caution: Harvard may be hazardous to your health") concerns the acceptance of a grant from six major cigarette companies to the Channing Laboratory. The grant is intended for research "to help resolve some of the questions that now exist concerning the effects of cigarette smoking." The press release of the Harvard researchers parroted the tobacco industry line of the last 25 years that "A direct causal relationship" between cigarettes and disease has never been demonstrated. The release failed to even mention the conclusions of the U.S. Surgeon General, the American Cancer Society, or the American Heart Association. The editorial argued that:

to the extent that accepting the tobacco company grant contributes to the doubt among non-medical people about the validity of medical evidence against cigarettes, the project sponsors are culpable and condemnable.

Strong words, but supported by articles relating the maneuvers of the tobacco industry to discredit scientific evidence implicating cigarettes in the development of heart disease, lung cancer, and chronic pulmonary disease.

Future issues of *The Present Illness* will be devoted to occupational health, day care, Indochina, women, and other topics that warrant discussion because of their importance and immediacy.

Response

The most tangible evidence of a favorable response to the newspaper has been the financial contributions. Letters of support and encouragement often accompany donations, which range from one to twenty-five dollars. Faculty members have been the most generous and consistent supporters, but medical students, secretaries and other employees have also been enthusiastic. Requests for reprints of specific issues to be sent to people at other universities across the country and abroad are another positive feedback.

Only a handful of correspondents have disapproved of particular issues. We would actually like to see more disagreement, since that would be a sign that we're reaching a wider audience than our supporters!

Toward What End?

Why publish *The Present Illness* at all? It consumes a great deal of time, has a circulation of only 500–750, and costs over $300 for 10 issues! For one thing, the research invested in particular issues is in itself valuable, and often reveals information that puts topics in a new light. Much of the material contained in the February and April issues of *The Present Illness* on Drs. Ebert and Stare appeared subsequently in an article in October's *Washington Monthly*. Several students who filed conscientious objector applications with the Selective Service System quoted material from the Medicine and War issue.

Second, knowing that *The Present Illness* exists encourages people to at least consider what the political and ethical implications of certain of their decisions may be. While it is no *Washington Post*, *The Present Illness* can publicize throughout the Harvard medical area controversial issues that *Focus* or the *Gazette* would not touch.

Finally, putting out *The Present Illness* is fun. It provides an incentive to keep up with newspapers and news magazines, an outlet for creativity in a field (i.e., medicine) that rewards compulsiveness, and a vehicle for controversy and protest. Even the American Medical Association approves of the goals of *The Present Illness*. Section 10 of the AMA Principles of Medical Ethics reads:

The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

HARVARD MEDICAL SCHOOL ANNOUNCES

The William O. Moseley, Jr. Travelling Fellowships

THE BEQUEST OF JULIA M. MOSELEY MAKES AVAILABLE FELLOWSHIP FUNDS FOR GRADUATES OF THE HARVARD MEDICAL SCHOOL FOR POSTDOCTORAL STUDY IN EUROPE.

The Committee on Fellowships in the Medical School has voted that within the funds available the amounts awarded for stipend and travelling expenses will be determined by the specific needs of the individual.
In considering candidates for the Moseley Travelling Fellowships, the Committee will give preference to those Harvard Medical School graduates who have—

1. **Already demonstrated their ability to make original contributions to knowledge.**
2. **Planned a program of study which in the Committee's opinion will contribute significantly to their development as teachers and scholars.**
3. **Clearly plan to devote themselves to careers in academic medicine and the medical sciences.**

Individuals who have already attained Faculty rank at Harvard or elsewhere will not ordinarily be considered eligible for these awards.

There is no specific due date for the receipt of applications or for the beginning date of Awards except that the Committee requests that applications not be submitted more than 12 months in advance of the requested beginning date. The Committee will meet once a year in January to review all applications on file. Applicants will be notified of the decision of the Committee by January 31. The Committee may request candidates to present themselves for personal interviews.

Application forms may be obtained from, and completed applications should be returned to:

Secretary, Committee on Fellowships in the Medical School
Harvard Medical School
25 Shattuck Street, Boston, Massachusetts 02115